Supreme Court, U.S.
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No.

IN THE

Supreme Court of the United States

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA,

Petitioner,

v.

UNIBELL ANESTHESIA, P.C.,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF THE STATE OF NEW YORK, APPELLATE DIVISION, FIRST DEPARTMENT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. May an ERISA fiduciary be sued in state court, under state law, for allegedly misrepresenting acts it performed as an ERISA fiduciary?

2. May an action seeking damages against an ERISA fiduciary based upon an interpretation of the terms of an ERISA plan be maintained in state court, under state law?

3. May an action be maintained in state court, under state law, to determine what information must be disclosed by an insurer/ERISA fiduciary to the employer/plan administrator during the renewal of an ERISA plan?

4. Are constructive fraud, negligent misrepresentation, unjust enrichment, and a New York common law based statute which allows for rescission of insurance policies and a refund of all premiums paid, without an offset of claims paid, laws regulating insurance within the meaning of the ERISA savings clause?

5. May punitive damages be awarded against an ERISA fiduciary in state court, under state law, for performing acts related to its fiduciary duties?

STATEMENT PURSUANT TO RULE 29.6

There is no parent or publicly held company owning 10% or more of the stock of The Guardian Life Insurance Company of America.

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Petitioner, The Guardian Life Insurance Company of America, respectfully requests that a writ of certiorari be issued to review the order of the Supreme Court, State of New York, Appellate Division, First Department in this case. The New York Court of Appeals declined to review the order.

OPINION BELOW

The opinion of the Supreme Court, State of New York, Appellate Division, First Department is reported at *Unibell Anesthesia, P.C. v. The Guardian Life Insurance Company of America*, 682 N.Y.S.2d 193, 1998 N.Y. APP. DIV. LEXIS 13928. Leave to appeal was denied by the New York Court of Appeals, 1999 N.Y. LEXIS 1250.

STATEMENT OF JURISDICTION

The order of the New York Supreme Court, Appellate Division was entered on December 29, 1998 (Appendix A, 1a). The Appellate Division denied a timely motion of The Guardian Life Insurance Company of America for reargument by order dated February 11, 1999 (Appendix C, 12a). The New York Court of Appeals denied the timely motion of The Guardian Life Insurance Company of America for leave to appeal by order dated May 13, 1999 (Appendix D, 14a).

The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a).

STATUTES AND LAW INVOLVED

The statutes and law involved are 29 U.S.C. § 1132, § 1144 and New York Insurance Law § 4226. The relevant portions are in Appendix E, 16a.

STATEMENT OF THE CASE

In 1977, defendant, The Guardian Life Insurance Company of America ("Guardian"), issued a policy of group health insurance to plaintiff, Unibell Anesthesia, P.C. ("Unibell"), for the benefit of its employees and their dependents. The policy was an "employee welfare benefit plan" under the Employees Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*

The term of the contract was for one year. There was a provision for annual renewal at the option of the parties at a premium proposed by Guardian (607a; 623a).[1] The policy was renewed annually through the end of 1993. Guardian was an ERISA fiduciary. The policy provided that "Guardian is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims" (680a). The ERISA plan does not name a plan administrator (607a). In such a case Unibell, as the plan sponsor, is the administrator. 29 U.S.C. § 1002(16)(A)(ii).

In 1994 Unibell commenced this action in the Supreme Court, State of New York, County of New York, seeking recovery upon various state common law and statutory claims, based upon allegations that Guardian failed to disclose that a certain Unibell employee (Ms. Greta Filler), who suffered from a serious illness and had incurred high medical expenses, had become eligible for Medicare benefits. The theory of the case was that this information was concealed from Unibell and the effect of Medicare on the prospective risk of Guardian was not considered when annual premium rates were proposed by the insurer (17a).

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1. References are to the pages of the record on appeal to the New York Supreme Court, Appellate Division, First Department.

Guardian did not remove the case to the Federal District Court at that time since the allegations did not appear to implicate the obligations of Guardian as an ERISA fiduciary under existing federal law.

The action proceeded through discovery. Guardian's motion for summary judgment, on state law grounds, was denied. The denial was affirmed on appeal.

A few weeks prior to the scheduled trial date the parties exchanged proposed jury instructions. Unibell's proposed charges made an unpleaded argument the central focus of the case. This contention was that, in the 1991 ERISA plan renewal proposal, Guardian deliberately overstated the amount of claims paid during the 1990-1991 policy year to induce Unibell to renew the policy at an excessive premium. The renewal proposal stated that "incurred claims" for the prior policy year were $1,118,841.70 (132a).[2] Unibell contended that approximately $500,000 of the claims paid were charges for medical services rendered to Ms. Filler during policy years prior to 1990-91. It was contended that Guardian overstated the claims to induce Unibell to renew the plan at the proposed increased rates (*See, e.g.*, 1001a-1002a; 1031a-1032a).

Guardian immediately moved to preclude the introduction of any evidence on these issues at the impending trial upon the basis that the allegations charged Guardian with a breach of its duties as an ERISA fiduciary (34a). ERISA fiduciary breach claims are matters of exclusive federal subject matter jurisdiction. 29 U.S.C. § 1132(e).

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2. "Incurred claims" are the claims paid plus a reserve for unfiled claims less the beginning reserve (814-15). This is the standard National Association of Insurance Commissioners definition for claims reporting purposes in all fifty states (814-16).

In response to this motion, Unibell moved to add allegations to the amended complaint that the claims paid for 1990-91, as reported in the 1991 renewal proposal, included amounts that were paid during that policy year for medical services rendered to Ms. Filler during earlier policy years (60a). Ms. Filler had been hospitalized for several years. Due to a dispute between the hospital and the primary carrier (Blue Cross), charges in the amount of approximately $500,000 for services rendered during 1988-90 were not billed to Guardian until 1991 (267a). It was Unibell's theory that Guardian committed a fraudulent act by reporting such payments (made as an ERISA fiduciary) as 1991 claims.[3] Recovery was sought for common law fraud, constructive fraud, negligent misrepresentation, unjust enrichment, and for alleged violations of two New York statutes, together with punitive damages.

Unibell also contended that the 1991 claims reported in the renewal proposal were inflated by double counting, in that Unibell (erroneously) contended that Guardian included amounts paid for prior years' claims in the totals reported for the year the services were rendered *and* for the year claims for such services were paid.

Over Guardian's objection, Unibell was granted leave to amend the amended complaint, as requested, on the day the trial commenced (10). Allegations were added to the

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3. The ERISA contract stated that a "covered charge" resulted if a medical service was provided to an insured person when the policy was in force (646a). This protects an insured against the effects of a cancellation of the policy before a claim is made for such charges. As discussed in Point I, a claim cannot exist under the ERISA plan until a claim is filed with the insurer (628a). Unibell's new theory of recovery reversed these concepts.

complaint which contended that Guardian had engaged in a "fraudulent scheme . . . to obtain grossly excessive health insurance premium payments from plaintiff UNIBELL by misrepresenting the extent of GUARDIAN'S risk under a group health insurance plan issued by GUARDIAN for the employees of UNIBELL" (17a).

Guardian argued that the newly alleged wrongdoings related to the administration of an ERISA plan and, as such, were preempted by ERISA. The ERISA preemption arguments of Guardian were rejected by the trial court upon the basis that the newly alleged fraudulent activities occurred while Guardian was occupying the role of a seller of insurance, not while acting in its capacity as an ERISA claims fiduciary (8). The fact that the allegations related to Guardian's ERISA claims fiduciary status was not considered to be significant.

Guardian requested a recess to permit the filing of a removal petition. This was denied and the trial commenced immediately (11). The removal petition was filed later that day (972a). Unibell's motion to remand was granted by the United States District Court, Southern District of New York (Hon. John S. Martin, Jr.), upon the basis that "the notice of removal was not timely filed" (974a). As discussed, *infra*, this order necessarily implies a finding of ERISA preemption. The trial resumed in state court. Guardian was granted leave to amend its answer to respond to the new allegations which were added to the existing causes of action. Guardian raised the defense that it was the claims fiduciary of the ERISA plan, that the allegations of the newly amended complaint contended that Guardian breached its ERISA fiduciary duties, and that each cause of action of the complaint was preempted by ERISA (347-48).

As discussed, the policy provided that a "covered charge" exists from the time a medical service is rendered. During the trial Unibell repeatedly contended that a *claim*, not a charge, was incurred when a medical service was provided. (This contention is contrary to the terms of the ERISA plan). This was the premise for the central trial argument that Guardian did not accurately report the claims paid when it included in the 1991 renewal proposal claims paid during the prior policy year which were for medical services received during the prior and earlier policy years.

Unibell called one expert witness, Alan Rockman, an insurance broker and an attorney. The substance of Mr. Rockman's testimony was contrary to the express terms of the ERISA plan. Mr. Rockman stated that he had thirty years experience in the insurance industry in the design and administration of group health insurance programs. Mr. Rockman testified as follows:

> Q. In general parlance of the insurance industry, is there a common understanding of what it means to say that claims were incurred during a particular period of time?
>
> A. Yes.
>
> Q. And what is that understanding?
>
> A. Incurred means dates of service, that is when either somebody was in the hospital, somebody went to a doctor's office, that is the date of the service, the dates of service.

> Q. If a claim was incurred within a period it means that the date of the service was during that period?
>
> A. That's right, the medical services were rendered to that person in that time period.

(744).

On cross examination Mr. Rockman admitted that, under the plan, a *charge*, not a *claim*, was incurred when a medical service was rendered to an insured person. He acknowledged that such a charge must be submitted to an insurer for a claim to exist (766-67). Nevertheless, as discussed, *infra*, the contract and renewal offer incurred claims interpretation issues were submitted to the jury, and a verdict for Unibell on four state law causes of action, plus punitive damages, was rendered.

Mr. Rockman prepared a chart showing the effect of the "old claims" on the experience of the group for the policy year in question (576a). This chart was the basis for his calculation of Unibell's damage claim (745-57). In addition, in a further direct challenge to Guardian's administration of the ERISA plan, Mr. Rockman testified that, when computing premium rates for the next policy year, Guardian should not have considered any amounts paid during the prior policy year for services received by Unibell insureds during earlier policy years as current experience since, in his view, this would not be a proper basis for determining renewal premiums. (773).[4]

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4. Mr. Sanford Herman, a Vice-President and Actuary of Guardian, testified that approximately $285 million dollars is paid (Cont'd)

Several Unibell officers testified prior to Mr. Rockman. They also disputed the meaning of the ERISA plan. Dr. Herman Turndorf, the President of Unibell, testified that he understood "incurred claims" in the 1991 renewal offer to refer only to claims paid by Guardian for medical services received by covered persons during the prior policy year.

> Q. What was incorrect about saying Guardian had paid $1.1 million in claims in the just ending policy year?
>
> A. Well, incurred claims, it would seem to me meant that for the period September 1st, 1990 to August 31st, 1991 Guardian paid $1.18 million dollars for claims that were done for health care during that period of time.

(466).

Dr. Turndorf testified that Unibell would not have renewed the plan in 1991 and 1992 if he had known of the dates of the medical services paid during the 1990-91 policy year and the fact that Ms. Filler had become Medicare primary (434).

Mr. Richard Schiffer, a Unibell Vice-President, who is a CPA and attorney, testified that Guardian had misled Unibell concerning the "true claims" during the period in question (212-13). Mr. Schiffer also testified that Unibell

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(Cont'd)
annually by Guardian under group health plans for services provided to insureds during earlier years. Mr. Herman explained that Guardian would face financial ruin if unable to consider such amounts when calculating renewal premiums (827-28).

would not have renewed the plan in 1991 if he knew that the $1.1 million in claims in the 1991 renewal letter included $500,000 for medical care received two to three years earlier (104).

Specifically, Mr. Schiffer was referring to Guardian's 1991 payment of $500,000 to NYU Medical Center for medical services rendered in 1988-1989. The NYU hospital bills were paid by Guardian at the request of Unibell. In 1991 Guardian received a claim form signed by Unibell requesting payment of an NYU hospital bill from 1988-89 in the amount of $400,000 (393a). Guardian promptly paid the bill and sent an explanation of benefits form to Unibell stating that such payment had been made (750a). These actions were taken by Guardian as the ERISA claims fiduciary. The request for payment was made by Unibell, the administrator of the plan. The explanation of benefits was sent to Richard Schiffer, the person designated by Unibell to receive plan related correspondence (785a). The fact that the claims related to pre-policy year charges was indicated. At trial, Mr. Schiffer testified that the review of plan related correspondence was delegated to clerical employees (131-32). Unibell then recovered under state law for the alleged failure of Guardian to have provided such information to Unibell!

The assault on Guardian's administration of the ERISA plan continued to the end of the trial. On summation, the attorney for Unibell told the jury that Guardian was "caught red handed passing off hundreds of thousands of dollars of old claims as though they were incurred in the current year . . . ," (1155) adding that it was "outrageous" to include "old claims" in the current claims experience of the insurer (1157). In repetition of the argument of Unibell's expert, the jury was also told that the $1.1 million amount was not a credible number and should not have been included in the renewal letter (1131).

In the charge, the jury was instructed that Guardian made representations of the amount of incurred claims and that they were to decide whether such representations were false or created a false impression (1189-90). The jury was further to determine whether the failure to disclose the age of the claims "created a false impression and misled Unibell . . . ," or whether the incurred claims amounts were accurate, but misleading, absent other disclosures (1190-91). The jury was also charged to determine whether the alleged failure to disclose the Medicare status of Ms. Filler was required to "avoid making a disclosure of the incurred claim figures not misleading" (1189). These instructions were incorporated into the charges given on fraud, constructive fraud (1198-99), negligent misrepresentation (1203-04), unjust enrichment (1207), § 4226 of the New York Insurance Law, which prohibits an insurer from misrepresenting the "terms, benefits or advantages" of a policy (1209), § 349 of the New York General Business Law (unfair business practices) (1209-11), and on the claim for punitive damages (1214-15).

The jury returned a verdict for Unibell on the constructive fraud, negligent misrepresentation, unjust enrichment and Insurance Law § 4226 causes of action. Punitive damages in the amount of $250,000 were awarded based upon the constructive fraud finding (1268-71).

REASONS FOR GRANTING THE WRIT

I.

THE PETITION SHOULD BE GRANTED BECAUSE THE OPINION BELOW CONFLICTS WITH THIS COURT'S PRIOR RULINGS ON SEVERAL ASPECTS OF ERISA.

A. This Action "Relates To" An ERISA Plan

The New York Supreme Court, Appellate Division, First Department was presented with numerous ERISA related issues which were disposed of by a complete misapplication of fundamental principles declared by this Court.

29 U.S.C. § 1144(a) provides for preemption of state laws that "relate to" an ERISA plan. Prior to *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company*, 514 U.S. 645 (1995), the scope of "relate to" was somewhat uncertain. Some courts had declared that any issues concerning an ERISA plan necessarily "relate to" the plan. Other courts had taken a more restrictive view of the term. In *Blue Cross* this Court adopted a pragmatic and functional approach and declared that "[t]he basic thrust of the preemption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 657. Any state laws which impede that goal "relate to" a plan for preemption purposes. *Id.* at 657-660.

As discussed, the Unibell ERISA plan gave Guardian the discretionary authority to "determine eligibility for benefits and to construe the terms of the plan with respect to

claims" (680a). In 1991 Guardian received claims for Greta Filler for medical services provided to her between 1988-1990. Unibell, the plan administrator, requested that payment be made (393a). The claims were payable under the terms of the ERISA plan. Guardian promptly paid the claims as the ERISA fiduciary and gave Unibell notice of payment (750a). Yet Guardian was found liable for damages on several state law causes of action, plus punitive damages, for including these amounts in the claims for that policy year as reported in the annual renewal proposal.

The basis for this liability was the false contention that Guardian passed off "old claims" as current payments. Yet, these were not "old claims" under the ERISA plan.

The essence of the plaintiff's action involved a challenge to the terms of the ERISA plan and Guardian's obligations under that plan. The ERISA plan obligated Guardian to pay the claims in question and did not require reporting by dates of service. Consequently, the inclusion of those claims in the amount of incurred claims for the prior policy year is consistent with the plan. Any state law challenge to the payment or reporting "relates to" the plan since it, in essence, challenges Guardian's administration of the plan when viewed in the light of the ERISA pleading rules. The well pleaded complaint rule does not apply to ERISA. Thus a state court complaint, purporting to allege state law issues, will be preempted if it encroaches on an area of exclusive federal concern, such as challenges to acts which constitute the administration of ERISA plans or have an adverse financial impact upon such plans. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987).

Could any action have a greater impact on the administration of ERISA plans than state court

misconstructions of such plans, resulting in the award of damages for acts performed in compliance with a plan and the imposition upon ERISA fiduciaries of duties inconsistent with the terms of a plan?

Guardian accurately reported its proper ERISA claims fiduciary activities in the 1991 renewal proposal. Any disputes concerning such acts which have the potential to impede the uniform national administration of ERISA plans "relate to" such plans and must be preempted.

Moreover, the solvency of ERISA plans requires adequate planholder contributions. Any challenges to the renewal premium calculation practices of an insurer must be deemed to "relate to" a plan for the same reasons.

B. *Varity Corp v. Howe* Expanded The Concepts Of ERISA Plan Administration And Fiduciary Duties

Guardian was the ERISA claims fiduciary. The state court opinions held that none of the policy renewal allegations of Unibell constituted a claim for ERISA fiduciary breach because Guardian was found to have been acting as a seller of insurance, not as a claims fiduciary, at those times.

In *Varity Corp. v. Howe*, 516 U.S. 489 (1996), this Court expanded the circumstances under which an ERISA fiduciary acts in that capacity. The acts at issue in *Varity* involved representations by the petitioner, an ERISA plan administrator, concerning a subsidiary, where the representations were made to induce respondents to transfer their employment and their pensions to the subsidiary. The issue was whether ERISA fiduciary obligations are limited

solely to acts of plan administration performed as a fiduciary or whether the duties of an ERISA fiduciary are broader in scope. Varity claimed it was acting as an employer, not as an ERISA fiduciary, when it spoke and that none of the representations related to Varity's administration of the ERISA plan. *Id.* at 495.

This Court incorporated the general duties of trustees into ERISA. Varity was found to have acted in a fiduciary capacity when it made the representations while exercising "such powers as are necessary or appropriate for the carrying out the purposes" of the plan, including "[c]onveying information about the likely future of plan benefits, thereby permitting beneficiaries to make an informed choice about continued participation" in the plan. *Id.* at 502. This Court accepted the factual finding that Varity intentionally misrepresented to its employees that the entity to which they were requested to transfer their employment was financially stable and, thus, their ERISA benefits under the new plan would be secure. "And we hold that making intentional representations about the future of plan benefits in that context is an act of plan administration." *Id.* at 505.

In the present matter, Guardian is alleged to have induced Unibell to renew the plan in 1991 "by misrepresenting the extent of GUARDIAN's risk under a group health insurance plan issued by GUARDIAN, of the employees of UNIBELL." "Guardian's risk" under the plan was the amount of claims it would have to pay as an ERISA fiduciary. Unibell's contention that this risk was misrepresented by the inclusion of the "old claims" in the 1991 renewal proposal, thereby inducing Unibell to pay an excessively high premium, constituted allegations of fiduciary breach under *Varity*.

In the present matter, we have a decision of the New York Supreme Court, Appellate Division, which the highest court of New York declined to review. The decision states that Guardian's preemption claim fails "since defendant, at the time of the misrepresentations upon which plaintiff's fraud claim is premised, was merely engaged in the sale of additional insurance — an activity plainly subject to State regulation, ERISA notwithstanding — and not acting in the capacity of an ERISA claims fiduciary." (App. 2a). This decision, narrowly confining ERISA fiduciary duties only to the described fiduciary status of the entity, flies in the face of *Varity*. It will lead to other misapplications in state court unless reviewed by this Court.[5]

Several United States Courts of Appeals have addressed preemption of ERISA sales related issues. The subject state court decision conflicts with these precedents.

In *Woodworker's Supply Inc. v. Principal Mutual Life Ins. Co.*, 170 F.3d 985 (10th Cir. 1999), the Court analyzed decisions in several circuits on the issue of the preemption of fraudulent inducement claims arising out of the sale of ERISA plans, and concluded that such actions have only been permitted in state court, or in federal courts under state law, when brought against a party that was *not* an ERISA entity at the time the challenged acts were performed. *Id.* at 990-

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5. The reference of the Appellate Division to "defendant's failure to raise the preemption issue as a defense in its answer or in its pretrial motions" is erroneous. The issues related to the "incurred claims" were added to the complaint on the day the trial commenced. Guardian amended its answer to include the ERISA jurisdictional issue. The Appellate Division also failed to consider the non-waivable nature of a subject matter jurisdiction defense based upon complete preemption.

92. These cases included insurers which were not ERISA fiduciaries prior to the sale and insurance brokers who never achieved that status. "Holding insurers accountable for pre-plan fraud does not affect the administration or calculation of benefits, nor does it alter the required duties of plan fiduciaries." *Id.* at 992.

The *Woodworker's* Court noted that fraudulent inducement claims "affecting relations between primary ERISA entities" have been preempted. *Id.* at 990-91. The instant matter deals with the renewal of a plan between such ERISA entities (employer/administrator and claims fiduciary) in which Guardian's administration of the ERISA plan was challenged. Unibell has standing to sue Guardian in federal court for alleged breach of fiduciary duties. 29 U.S.C. § 1132(a)(2). A state court cause of action is preempted if it "conflicts directly with an ERISA cause of action." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142-43 (1990).

C. The Allegations Of Unibell Cannot Be Evaluated Without Reference To The ERISA Plan And Are Consequently Preempted

Rice v. Panchal, 65 F.3d 637, 644 (7th Cir. 1995), *Amended by, Rehearing, en banc, denied by Rice v. Panchal*, 1995 U.S. App. LEXIS 31419 (7th Cir. 1995), discussed several decisions of this Court and observed that "[t]he common thread running through those cases is that complete preemption is required where a state law claim cannot be resolved without an interpretation of the contract governed by federal law." The Court noted that the preemption criteria under the Labor Management Relations Act are applicable to ERISA. *Id.* at 643. *See Allis-Chalmers Corp. v. Lueck*,

471 U.S. 202, 213-14 (1985), in which it was declared that "[w]hile the nature of the state tort is a matter of state law, the question whether the Wisconsin tort is sufficiently independent of federal contract interpretation to avoid preemption, is, of course, a question of federal law."

Guardian was found liable for constructive fraud, negligent misrepresentation, unjust enrichment, violations of New York Insurance Law § 4226 and for punitive damages based upon a theory that was entirely dependent upon a misinterpretation of the ERISA plan. If such actions are not preempted, the goal of uniform administration of ERISA could be subverted through state court allegations of tort or ambiguity-based claims relying upon misinterpretations of ERISA plans. Actions involving the meaning of ERISA plans must be litigated in federal courts where the emerging body of common law applicable to ERISA can be consistently applied. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-111 (1989).

Guardian does business in all fifty states and in the District of Columbia (816). In applicable Labor Management Relations Act precedent, this Court recognized in *Lingle v. Norge Division of Magic Chef, Inc.*, 486 U.S. 399, 405-06 (1988), that state law claims based upon interpretations of contracts governed by federal law must be preempted. Otherwise "there could be as many state-law principles as there are States." *Id.* at 406.

D. The Rule Of Law Upon Which The Judgment Was Based Would Create Financial Havoc For ERISA Plans

This Court has declared that state laws may not create a significant, direct financial impact on ERISA plans. *New York Blue Cross*, *supra*, 514 U.S. at 659-660. Guardian pays approximately 285 million dollars annually for claims for medical services received by insureds during earlier years (827-28). Under the Unibell judgment Guardian is liable for not identifying the claims from earlier policy years in the 1991 renewal proposal. If Guardian is unable to account for these payments in its renewal proposals, it would create financial havoc for ERISA plans.

Moreover, in order to avoid similar results in the future, Guardian would be required to report claims differently in New York than in the rest of the country. This is an impact which state law cannot be allowed to have upon an ERISA plan.

E. The District Court Remand Order Recognized That This Action Was Preempted By ERISA

Guardian removed the action to the United States District Court, Southern District of New York, on the day that leave was granted to add the incurred claims issues to the complaint. The District Court (Hon. John S. Martin, Jr.) remanded the action because "the notice of removal was not timely filed . . ." (974a). Implicit in this determination is a finding that ERISA was implicated and that removal would have been timely if sought within thirty days of the date ERISA issues were first raised by Unibell. Pursuant to 28 U.S.C. § 1446(b), removal must be effected within thirty

days after receipt of the initial pleading, if then removable, or within thirty days after receipt of a copy of an "amended pleading, motion, order or other paper from which it may first be ascertained that the case is one which is or has become removable."

During the argument of the motion, Judge Martin suggested that the original alleged non-disclosure of Ms. Filler's Medicare status issue may also have alleged a fiduciary breach. If this was indeed the Court's belief, then removal two years later would have been considered untimely.

Remand could not confer jurisdiction on the state court for a claim for breach of ERISA fiduciary duties. If removal was untimely, remand was mandatory even if the action was beyond the jurisdiction of the state courts. *See Stack v. Strang*, 191 F.2d 106 (2nd Cir. 1951).

Guardian did not remove the action when it was originally commenced in 1994. Under the law as it then existed, allegations that an ERISA fiduciary intentionally failed to advise a plan that one of the members of the group had become covered by Medicare did not appear to state a claim for fiduciary breach. For the reasons discussed, *infra*, *Varity v. Howe*, decided two years later, changed, or at least clarified, significantly the law in this area.

The jury charge incorporated the Medicare issues into the incurred claims allegations, eliminating any distinction between the two theories. The jury was instructed that Unibell alleges that "Guardian omitted to state in 1991 and 1992 renewal letters that Medicare had become a primary insurer for Greta Filler as of April, 1991. Unibell claims that the

disclosure of this fact was required to avoid making a disclosure of the incurred claim figures not misleading." (1189). Thus, the incurred claims issues as presented to the jury encompassed the Medicare allegations.[6]

II.

THE STATE COURT DECISION MISAPPLIED THE ERISA "SAVINGS CLAUSE".

29 U.S.C. § 1144(b)(2) states that "[e]xcept as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." This is the ERISA "savings clause." Subparagraph (B) contains inapplicable provisions concerning non-insurance based employee benefit plans.

The decision of the Appellate Division cited "*John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99-100; [and] *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 727-730" in support of the proposition that the state may regulate the sale of insurance involved in the renewal of an ERISA plan and upheld recovery against Guardian on common law causes of action and a statutory claim which is based upon generally applicable common law principles.

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6. It should be noted that Guardian, while acting as the ERISA claims fiduciary, sent many documents to Unibell indicating that Ms. Filler was covered by Medicare. *See, e.g.*, 800a-821a. These documents evidence Medicare payments followed by submission of the balances to Guardian for payment. Medicare was thus shown to have been the primary payor.

Both cases cited by the Appellate Division discussed only the ERISA savings clause at the pages referenced.

The Appellate Division decision completely disregarded the basic principle that the savings clause exempts from preemption only state laws which are "limited to entities within the insurance industry." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985). *See also Unum Life Ins. Co. of America v. Ward*, __ U.S. __, 119 S. Ct. 1380, 1386, 143 L. Ed. 2d 462, decided on April 20, 1999.

The decision of the Appellate Division did not distinguish between the common law and statutory claims. All were given the blanket protection of the savings clause.

Constructive fraud, negligent misrepresentation, unjust enrichment, and punitive damages are New York common law causes of action or remedies that apply to everyone and, by definition, cannot be laws regulating insurance because they are not directed at the insurance industry. *Unum Life*, *supra*, 119 S. Ct. at 1386-1388.

Likewise, Insurance Law § 4226 has been held not to fall within the savings clause since it "merely codifies general principles of common law fraud in an attempt to limit unfair trade practices." *DeBruyne v. Equitable Life Assur. Society*, 920 F.2d 457, 469 (7th Cir. 1990).[7]

As recognized in *DeBruyne*, § 4226 provides a rescissionary type remedy for misrepresentations of the

7. New York Insurance Law § 4226(a)(1) prohibits an insurer from misrepresenting the "terms, benefits or advantages" of a policy. Plaintiff recovered the statutory penalty of all premiums paid for the 1991-92 policy year under that statute.

"terms, benefits or advantages" of an insurance policy, based upon common law fraud principles which would be applicable in any other state contract action. *Id.* at 469-470. In *Unum Life*, *supra*, 119 S. Ct. at 1387, this Court held that a state law based upon generally applicable common law principles cannot be a law regulating insurance.

Preemption is also required because a state law cause of action cannot contain a remedy inconsistent with those available under ERISA. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53-56 (1987). § 4226(d) of the New York Insurance Law provides for a super rescissionary penalty since the claims paid by an insurer are not offset against premiums refunded. There is no such remedy available under ERISA. *See* 29 U.S.C. § 1132.

It should also be noted that the alleged misrepresentations which were the basis for recovery under the statute are the same incurred claims arguments shown in Point I to be preempted.

Pilot Life also reiterated that ERISA does not provide for the granting of punitive damages. *Id.* at 53-54 (citing *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985)). Unibell was awarded punitive damages in the amount of $250,000 (1271). The award of punitive damages is an illustration of the consequences of litigating ERISA fiduciary breach actions in state courts.

Sanford Herman, a Vice President and Actuary of Guardian, testified that the underwriters computed the renewal premium offer for the 1991-92 policy year by reviewing the experience of the group for the preceding year. Mr. Herman explained that the premium offered to Unibell,

when adjusted for inflation, discounted the group's experience for the just completed year by approximately 50% (872). The proposed premium for 1991-92 was approximately $700,000 and the claims for 1990-91 had been $1.18 million (132a). Mr. Herman explained that 50% of the experience from the 1990-91 year was not credible, meaning that it was thought unlikely to recur (839-40). The amount discounted equaled the $500,000 NYU Hospital bills.

However, on the post-trial motion to set aside the verdict, the trial court misinterpreted this testimony and concluded that Guardian had defrauded Unibell when it reported the amount of incurred claims for 1990-91.

> There is no doubt that the verdict on the punitive damage claim as well as the constructive fraud are sufficient to show that the jury found a knowing violation of Section 4226. The testimony showed that Guardian believed that its own underwriter had disregarded at least 50% of the amount shown on the renewal letter sent to plaintiff.

(9a).

The explanation of Mr. Herman that Guardian discounted half of the experience as not likely to recur, and reduced the premium requested accordingly, was distorted into a misstatement that Guardian presented a number in the ERISA renewal proposal that it didn't believe was accurate.

In reality, the renewal offer correctly stated the amount of incurred claims as a historical fact (132a). There was no misrepresentation as a matter of law. But even if there were a question in this regard, it would be an issue which only a federal court has the jurisdiction to address.

CONCLUSION

The magnitude of the incursion of the state courts into exclusive federal ERISA jurisdiction, which occurred in this action, is unprecedented. Review by this Court is of exceptional importance to ERISA jurisprudence.

Respectfully submitted,

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APPENDIX

APPENDIX A — JUDGMENT OF THE SUPREME COURT OF NEW YORK FOR THE APPELLATE DIVISION, FIRST DEPARTMENT DATED AND ENTERED DECEMBER 29, 1998

Lerner, P.J., Wallach, Tom, Andrias, JJ.

3224

Unibell Anesthesia, P.C.,

Plaintiff-Respondent,

Steven E. Obus

– against –

The Guardian Life Insurance Company of America,

Defendant-Appellant.

Robert D. Meade

Judgment, Supreme Court, New York County (Lewis Friedman, J.), entered October 30, 1997, which, upon a jury verdict in plaintiff's favor, awarded plaintiff $746,000 in compensatory damages and $250,000 in punitive damages, as well as a statutory penalty of $805,719 pursuant to Insurance Law § 4226(d), plus interest, costs and disbursements, for a total amount of $2,176,152.56, and bringing up for review an order of the same court and Justice, entered October 23, 1997, *inter alia*, denying defendant's motion to set aside the verdict on the ground that the court

lacked subject matter jurisdiction or as against the weight of the evidence, unanimously affirmed, with costs.

The jury's finding in plaintiff's favor on its causes of action for constructive fraud, negligent misrepresentation, unjust enrichment and violation of Insurance Law § 4226 was amply supported by the evidence showing that misrepresentations and omissions by defendant insurance company had induced plaintiff to pay exorbitant premiums for its group health coverage for policy years 1991 and 1992. The proof, also supported the jury's awards of damages, both the punitive and compensatory, in the above amounts.

In addition to challenging the verdict as against the weight of the evidence, defendant contends that the subject action is preempted by the Federal Employee Retirement Security Act ("ERISA") (29 USC § 1001, *et seq.*). However, even if it were appropriate to disregard defendant's failure to raise the preemption issue as a defense in its answer or in its pretrial motions, defendant's preemption claim would still fail since defendant, at the time of the misrepresentations upon which plaintiff's fraud claim is premised, was merely engaged in the sale of additional insurance — an activity plainly subject to State regulation, ERISA notwithstanding — and not acting in the capacity of an ERISA claims fiduciary (*see*, *John Hancock Mut. Life Ins. Co. v Harris Trust & Sav. Bank*, 510 US 86, 99-100; *Metropolitan Life Ins. Co. v. Massachusetts*, 471 US 724, 727-730).

We have considered defendant's remaining arguments and find them to be unpersuasive.

Appendix A

THIS CONSTITUTES THE DECISION AND ORDER
OF THE SUPREME COURT, APPELLATE DIVISION,
FIRST DEPARTMENT.

ENTERED: DECEMBER 29, 1998

s/ [illegible]
CLERK

APPENDIX B — ORDER OF THE SUPREME COURT OF THE STATE OF NEW YORK FOR THE COUNTY OF NEW YORK, IAS PART 11 DATED OCTOBER 20, 1997 AND FILED OCTOBER 23, 1997

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: IAS PART 11

Index No. 129025/94
Seq. No. 009

UNIBELL ANESTHESIA, P.C.,

Plaintiff,

– against –

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA and PETER PECK,

Defendants.

LEWIS R. FRIEDMAN, Justice

Defendant Guardian moves to set aside the jury verdict entered against it in this case and for a dismissal of the complaint, on the ground that the court lacked subject matter jurisdiction, or for a new trial, on the ground that the verdict was against the weight of the evidence. Plaintiff cross moves for the court to set the amount of pre-verdict interest.

The court will not repeat the facts that have been set forth at length in the various pre-trial and appellate proceedings and the evidence at trial. Suffice it to note that

the jury found defendants liable for constructive fraud, negligent misrepresentation, unjust enrichment and a violation of Insurance Law § 4226 with respect to the 1991 renewal letter. The jury found in defendant's favor on the question of actual fraud, whether there was a violation of General Business Law § 349, and whether there was a violation of Insurance Law § 4226 with respect to the 1992 renewal letter. The jury found compensatory damages of $746,000 and awarded punitive damages of $250,000. The amount of the damages to be awarded pursuant to Insurance Law § 4226 was not submitted to the jury since, as the court and counsel agreed, there was a stipulated amount of damages, the premiums that had been paid and there was no issue of fact on that item.

Defendants' primary argument is that the entire action was preempted as a matter of federal law by ERISA. That issue was not made in the pretrial motions or on the prior appeal to the Appellate Division; it was brought up for the first time on the day set for the beginning of the trial. On that day, defendant removed the action to federal court. This court retained the jury and awaited the not unexpected remand the next day. In simple terms the argument made on this motion and on the motion at the beginning of the trial is that the claims made by plaintiff are essentially being brought against defendant Guardian, which is a "claims fiduciary." Therefore Guardian contends that it is subject to suit under ERISA solely in federal court and that the state common law causes of action are preempted (29 USC § 1144[a]).

In the pretrial motion defendant relied on the March 26, 1996 decision by Judge Jones in the United States District

Court for the Southern District of New York in ***Raff v Travelers Ins. Co.***, 90 Civ 7673. This court had previously noted that ***Raff*** appeared to be inconsistent with Second Circuit authority. Defendant on this motion discloses that in a decision filed May 26, 1997, more than one month before the trial of this case started, Judge Jones disclosed that relying on the recent Second Circuit authority she had *sua sponte* reconsidered the preemption question and directed that the case be tried both on ERISA grounds and the state law ground. The May decision found that the state law claims were not preempted by ERISA since the action did not involve "an action by an employee to collect benefits and it does not effect how benefits are calculated or paid. In fact, plaintiff's claims neither seek to enforce nor relate to the regulation or administration of any covered plan." The recent decision, which had not been made available to this court prior to a ruling based on the long out dated and recalled 1996 decision, is consistent with ***Geller v County Line Auto Sales, Inc.***, 86 F3d 18 [2d Cir. 1996], and other authorities which have made it clear that there is no preemption for matters that have "an indirect economic effect on choices made by insurance buyers, including ERISA plans" (***NYS Health Maintenance Org. Conference v Curiale***, 64 F3d 794, 803 [2d Cir. 1995]).

The majority of defendant's argument is based on its notion that the case is about how it reports its claims incurred or potential claims. The simple fact in this case is that plaintiff asserted that the method in which defendant sought renewals of the insurance policy was fraudulent and misleading. The causes of action relate to defendant's efforts to enter into a different contract with plaintiff than the one

that was expiring. There is nothing in any of the ERISA cases that precludes a fraud action based on statements made to the proposed insured. The court notes that there is no ERISA requirement that defendant submit any claims data in its request for a renewal policy. The decision to include claims data is one that Guardian chose for itself and this action related to the inadequacy and misleading nature of that data. It did not impact required reporting or the payment of any of the claims.

The fact that Guardian was a claims fiduciary had nothing whatever to do with the representations it made in attempting to sell additional insurance for the following year. The Supreme Court has made it clear that an expansive reading of whether a claims is "related to" an ERISA plan is not appropriate (***De Buono v. NYSA-ILA Medical & Clinical Services Fund***, 117 S Ct 1747; ***California Div. of Labor Stds. Enforcement v Dillingham Construction NA, Inc.***, 117 S Ct 832). The claim against defendant was simply not in its role as a claims fiduciary (***see Andujar v. Lenox Hill Hosp.***, 226 AD2d 179, 180).

Guardian itself notes that the standard for retention of state actions in the Second Circuit is more favorable than in some other circuits (reply memo. p.5). Pursuant to ***Geller*** even if there were a "tangential" impact on the plan's administration there is no basis for preemption. Thus Guardian's belated claim of ERISA preemption fares no better when made after trial than it did during jury selection. The court finds that there was proper subject matter jurisdiction in this court.

Appendix B

Defendant attacks the court's instruction with respect to the definition of "misleading." The court's review of the charge as given does not support the contention that the jury were incorrectly charged. There was a question for the jury whether the statements as given were misleading, even if literally true. The charge requested by Guardian would have confused the concepts of mental state and whether half-truths were given.

Defendant contends that the proof was inadequate to support a finding of punitive damages. The jury found a constructive fraud based on instructions that incorporated the elements set forth in ***Rocanova v Equitable Life Assurance Society***, 83 NY2d 603. To the extent that defendant contends that the verdict is inconsistent the claim is presented too late. Well established law holds that any claim of inconsistency in a verdict is waived unless the claim is presented before the discharge of the jury (***see, e.g., Grzesiak v General Electric Co.***, 68 NY2d 937, 939; ***Barry v Manglass***, 55 NY2d 803, 805-6; ***Echavarria v Cromwell Assocs.***, 232 AD2d 347). The court notes that the proof, considered in the light most favorable to plaintiff, the winning side, supports a finding that the conduct alleged, the "disclosure" of misleading information, on standard forms that were sent to over 10,000 policy holders, where the employees did not have the authority to conform the form to the facts of the case, was sufficient to support a finding of willful and wanton conduct aimed at the public at large. Even if the issue were preserved for review on this post-trial motion to set aside the verdict, the court finds no inconsistency with a finding of no actual intent to commit fraud with the finding of willful, malicious conduct. This case is a far cry from

Appendix B

Sobie v Katz Construction Corp., 189 AD2d 49, 53, where the finding of maliciousness was clearly inconsistent with a finding of no culpable conduct and a zero percentage of fault. Here the jury found a constructive fraud, unjust enrichment and negligent misrepresentation. Any inconsistency could have been resolved before the jury was disbanded, but defendant waived the claim during the trial. It is too late to attempt to preserve the issue at this time. The court does not find the award of punitive damages to be against the weight of the credible evidence.

Finally defendant argues that the penalty required by Insurance Law § 4226 should not be imposed because the charge failed to include the element of a knowing violation. Suffice it to note that defendant did not, when given the opportunity after the charge, call the matter to the court's attention (***Bichler v Eli Lilly & Co.***, 55 NY2d 571, 583, *overruled on other grounds sub nom.* ***Kaufman v Eli Lilly & Co.*** 73 NY2d 487). On the instant motion defendant argues that since the charge as given was correct to have the jury determine whether there was a violation of the statute, there was no requirement that the issue of whether the penalty would attach for a knowing violation was a failure by plaintiff to request a corrective instruction. The court is not persuaded by defendant's argument. The issue had always been whether the statements given by defendant to plaintiff was a "term, benefit or advantage" within the meaning of the statute. Thus the knowledge question was not discussed by the parties. The cases have held that where there is a failure to bring to the court's attention that an element of a cause of action was not included in the charge, there is a waiver of the claim (***e.g. DeLong v County of Erie,*** 60 NY2d 296, 306; ***Pogo***

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Holding Corp. v New York Prop. Ins. Underwriting Assn, 62 NY2d 969, 971).

The court is convinced that there is ample evidence to establish that if, as the jury found, there was a violation of the statute, the violation was knowing. Indeed, the instructions taken as a whole establish that the jury was advised that in order to find a constructive fraud it had to find "that Guardian knew that Unibell was acting under a mistaken belief that Guardian was primary for Greta Filler" and that the jury had to find that "Guardian had notice that Unibell was acting under a mistaken belief that Guardian was primary for Greta Filler's claims." There is no doubt that the verdict on the punitive damage claim as well as the constructive fraud are sufficient to show that the jury found a knowing violation of Section 4226. The testimony showed that Guardian believed that its own underwriter had disregarded at least 50% of the amount shown on the renewal letter sent to plaintiff.

In simple terms the court finds no basis to set aside the verdict or to grant judgment for defendant. Defendant's motion is denied in all respects.

Plaintiff's motion for pre-verdict interest appears to state the law and the facts correctly. There is no reason to deny the application.

The judgment should include interest on the fraud claim in the sum of $315,466.48. Additionally the jury verdict should be supplemented by the addition of $805,719 for the Third Cause of action, as the penalty for a violation of

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Insurance Law, Section 4226, since that appears to represent the premiums paid for the 1991 policy year.

The Clerk shall enter judgment in essentially the form annexed as Exhibit A to plaintiff's Notice of Cross Motion.

This shall constitute the decision and order of the court.

Dated: October 20, 1997

s/ [illegible]
J.S.C.

APPENDIX C — ORDER OF THE SUPREME COURT OF NEW YORK FOR THE APPELLATE DIVISION, FIRST DEPARTMENT DENYING REARGUMENT AND/OR LEAVE TO APPEAL TO THE COURT OF APPEALS DATED FEBRUARY 11, 1999

At a Term of the Appellate Division of the Supreme Court held in and for the First Judicial Department in the County of New York, on February 11, 1999

Present - Hon. Richard W. Wallach, Justice Presiding,
Alfred D. Lerner
Peter Tom
Richard T. Andrias, Justices.

M-236
Index No. 129025/94

Unibell Anesthesia, P.C.,

Plaintiff-Respondent,

-against-

The Guardian Life Insurance Company of America,

Defendant-Appellant.

Defendant-appellant having moved for reargument of, or in the alternative, for leave to appeal to the Court of Appeals from, the decision and order of this Court entered on December 29, 1998 (Appeal No. 3224),

Appendix C

Now, upon reading and filing the papers with respect to the motion, and due deliberation having been had thereon,

It is ordered that the motion be and the same hereby is denied in its entirety, with $100 costs.

ENTER:

s/ Catherine O'Hagan Wolfe
Clerk.

APPENDIX D — ORDER OF THE COURT OF APPEALS OF THE STATE OF NEW YORK DENYING MOTION FOR LEAVE TO APPEAL DATED MAY 13, 1999

State of New York,
Court of Appeals

At a session of the Court, held at Court of Appeals Hall in the City of Albany on the thirteenth ***day of*** May 1999

Present, HON. JOSEPH W BELLACOSA, *Senior Associate Judge, presiding.*

1-10 Mo. No. 291

Unibell Anesthesia, P.C.,

Respondent,

v.

The Guardian Life Insurance Company of America,

Appellant.

A motion for leave to appeal to the Court of Appeals in the above cause having heretofore been made upon the part of the appellant herein and papers having been submitted thereon and due deliberation having been thereupon had, it is

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ORDERED, that the said motion, insofar as it seeks leave to appeal from the Appellate Division order denying appellant's motion for reargument or, in the alternative, leave to appeal to this Court, be and the same hereby is dismissed upon the ground that such order does not finally determine the action within the meaning of the Constitution; and it is

ORDERED, that the said motion for leave to appeal otherwise be and the same hereby is denied. Chief Judge Kaye took no part.

s/ Stuart M. Cohen
Stuart M. Cohen
Clerk of the Court

APPENDIX E — RELEVANT STATUTES AND LAW

29 U.S.C. § 1132(a) and (e)

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought —

(1) by a participant or beneficiary —

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) of this section or under subsection (i) or (*l*) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged

violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

* * *

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

* * *

Appendix E

29 U.S.C. § 1144(a)

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

* * *

New York Insurance Law § 4226(a)(1) and (d)

§ 4226. Misrepresentations, misleading statements and incomplete comparisons by insurers

(a) No insurer authorized to do in this state the business of life, or accident and health insurance, or to make annuity contracts shall:

(1) issue or circulate, or cause or permit to be issued or circulated on its behalf, any illustration, circular, statement or memorandum misrepresenting the terms, benefits or advantages of any of its policies or contracts;

* * *

(d) Any such insurer that knowingly violates any provision of this section, or knowingly receives any premium or other compensation in consequence of such violation shall, in addition to any other penalty provided in this chapter, be liable to a penalty in the amount of such premium or compensation, which penalty may be sued for and recovered by any person aggrieved for his own use and benefit, in accordance with the provisions of the civil practice law and rules.

* * * *